CATHOLIC HEALTH SERVICES FINANCIAL ASSISTANCE APPLICATION

FACILITY: ____ **Account Number** ____________________

Patient Name: ______________________________ **Date of Birth**______________ **DOS** ____________________

Responsible Party: ____________________________ **SSN**__________________ **Daytime Phone** ________________

Address______________________________ ____**City**__________________________ **State**________ **Zip**____________

Employer: ______________________________ **FT/PT Work Number**______________ **Monthly Gross Income$**__________

Spouse's Name ___________________________ **SSN** ________________________ **Monthly Gross Income$** __________

Employer: ______________________________ **FT/PT Work Number**______________

Responsible Party's Other Income $ ______________ **Spouse's Other Income $** ____________

Family Size__________ **Annual Gross Household Income $**______________ **Ages of Dependent Children** ____________________

PROOF OF INCOME: A COPY OF THE FOLLOWING INFORMATION MUST ACCOMPANY YOUR APPLICATION IN ORDER TO PROCESS

Federal Tax Return (most recent) 1040 / 1040EZ
Current Pay Stub (Responsible Party and Spouse)
Other Income Source Documentation:

Self Employed Applicants:
Please provide last 2 complete Federal Tax Returns with profit & loss reportings

____Social Security	____VA Assistance	____Railroad Retirement	____Child Support	____Disability
____Life Insurance	____Pension	____Alimony	____Unemployment	____Worker's Comp
____Public Assistance	____Other: Please List:______________________________			____Annuity

ASSETS

Cash on Hand (include checking)	$__________
Savings	$__________
Stocks/bonds/Retirement funds	$__________
Auto:Model__________ Yr_____	$__________
Auto:Model__________ Yr_____	$__________
Home: Estimated Market Value	$__________
Other Assets______________	$__________
Other Assets______________	$__________
Total Assets:	$__________

LIABILITIES AND NET WORTH

Bank Loans	$__________
Total Credit Cards	$__________
Home Mortgage	$__________
______rent _______own	$__________
Other Liabilities _________	$__________
Other Liabilities_________	$__________
Other Liabilities_________	$__________
Total Liabilities	$__________

Net Worth (Assets - Liabilities) $__________

FIXED MONTHLY EXPENSES

House Payment/Rent	$__________
Utilities	$__________
Telephone	$__________
Cable TV	$__________
Medical Bills	$__________
Prescription Drugs	$__________
Insurance	$__________
Groceries	$__________
Child Care $________ Child Support $________	
Total Monthly Expenses	$__________

I hereby acknowledge that the information given to Catholic Health Services is true and correct to the best of my knowledge. I authorize Catholic Health Services to verify any or all information given and to obtain a consumer credit report to be obtained as deemed necessary. PROOF OF INCOME REQUIRED.

Patient/Guarantor's Signature____**Date**______________________

If you have any questions regarding this form, please contact the Facility Business Office Monday through Friday from 9:00 a.m. to 5:00 p.m. **10/2006**